

**Comments from**

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January 9, 2009

**Concerns****Claims versus Incident versus Occurrence**

These three terms are familiar to people who work in insurance. The terms are often used interchangeably. In the guidelines claim and incident are defined and given precise meanings; however, the terms are then used less precisely. It appears that incident is used in Part A Section 7.E. in a way that is inconsistent with the definition in Section 2.K. of part A.

Another challenge to clarity in the guidelines is that a self-insured has multiple roles. They function as both an insured and an insurer.

The difficulty of using these terms consistently in the guidelines suggests that those that those who respond to closed claim study will have equal or greater difficulty in responding consistently. In particular the allocation of dollars within an incident to the proper claim will present challenges.

**Allocation Among Claims**

Part A Section 7.J.(5) and (6) may present problems for reporting entities especially for self-insureds. The desired data simply may not exist.

**Allocation to and Definition of Entities**

Part A Section 2.O. defines a primary insuring entity; Reporting responsibilities are assigned to the primary insuring entity. Self-insurers are not explicitly considered to be primary insuring entities. Yet, they may very well be acting as such in the claims settlement and claims reporting processes.

Does an excess insuring entity have to cooperate with a self-insured who is responding to the closed claim survey?

The inclusion of self-insureds complicates the preparation of this Guideline. For example, Part A Section 6.E. & Part A Section 6.E.(1) seems logically inconsistent. Given 6.E.(1) the facility or provider becomes a SI which contradicts 6.E.(1)

On a less pedantic note, it is not clear how deductibles or SIRs, self insured retentions, are to be handled. Neither Part A Section 7.A nor Part E Table of Data Fields addresses the issue. It is even less clear if a self-insured is doing the reporting per Part A Section 6.C. or D. A related issue (see Part A Section 7.J.(1)(a) is when does a deductible become a SIR?

These concerns provide part of the answer to the discussion question on page 14.

A related concern is what if an entity does not have an aggregate limit. An entity may become self insured not by conscious choice but by neglect or disbelief that there could be that many claims for that much money.

What if the insuring entity is providing a policy where the LAE is within limits?

Do we want the fact that the defendants for different claims within an incident have different deductibles or SIRs to impact the allocation of claim costs and defense costs?

### **Estimation and Allocation of Economic and Noneconomic Damages**

Part A Section 7.K.(3) & (4) are problematic for many reasons. Consider the following scenarios:

1. You are a claims adjuster for an insuring entity. Your best estimate of economic damages is 2 million and your best estimate of noneconomic damages is 1 million for a total of 3 million. These best estimates include future economic damages. You are offered the chance to settle for 1.5 million. You settle the claim. What do you report? What do we want reported?
2. Consider the scenario listed above with the additional info that the claim is being litigated in California which has a \$250,000 cap on noneconomic damages. Again, what do you report? What do we want reported?

Selection of a discount rate, selection of a mortality table, selection of a length of disability, and consideration of issues of negligence and liability, the relative strength of the defense, and the component of the indemnity payment driven by economic damages are all subjective decisions. The decision may be guided by professional judgment but it is still subjective.

Kathy Zeiler's appeal for use of "estimates of damages that would have been awarded if the plaintiff had won at trial" disguises the use of a set of very subjective judgments to come up with a set of arbitrary values. Her proposal does not provide an objective answer. It is not a solution.

### **Other Concerns**

Part A Section 7.E. suggests reporting at the city level. The use of an online drop down box or a list of defined choices that is provided to the respondent will simplify collection of this data and eliminate many problems with typos and inconsistencies in the data provided. To be consistent and less onerous for all involved items 17 and 18 in Part E, Table of Data Fields should be dropped.

Part D in the third paragraph proposes a possible timing for the production of a report based on the data collected. Depending on the year that is attached to the date of 6/30 the schedule is very optimistic or very leisurely. Ohio's actual schedule with 2007 data required the data to be reported to the department by May 31, 2008. The tentative release date for the report is in February 2009 (Note that the Department relocated to a new address in May of 2008 so this is not a typical year.) We may want to expand this schedule or drop it.

This section could also be read to require that the Department must compare years. This may not be what we want to do.

Part A Section 7.J.(7) and Part A Section 2.G.(2) appear to contradict each other.

Part A Section 2.B. specifies that the claim identifier has to be numeric. Why? Why not allow alphanumeric codes?